

ONE HUNDRED FOURTEENTH CONGRESS
Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6115

Majority (202) 225-2927
Minority (202) 225-3641

MEMORANDUM

May 9, 2016

To: Subcommittee on Health Democratic Members and Staff

Fr: Committee on Energy and Commerce Democratic Staff

Re: Hearing on “Health Care Solutions: Increasing Patient Choice and Plan Innovation”

On **Wednesday, May 11th, at 10:00 a.m., in Room 2322 of the Rayburn House Office Building**, the Subcommittee on Health will hold a hearing titled “Health Care Solutions: Increasing Patient Choice and Plan Innovation.”

I. BACKGROUND

The Affordable Care Act (ACA) established state and federal insurance marketplaces to increase access to high quality health insurance coverage.¹ After the third open enrollment season this year, 12.7 million Americans had selected or were re-enrolled in plans offered on the state or federal marketplaces.² On the federal marketplace, approximately 42 percent of plans selected this year were made by new consumers entering the market. As a result of increased marketplace access and other relevant provisions in the ACA, 20 million Americans have

¹ U.S. Department of Health and Human Services (HHS), *Key Features of the Affordable Care Act by Year* (Aug. 13, 2015) (online at <http://www.hhs.gov/healthcare/facts-and-features/key-features-of-aca-by-year/index.html>).

² Centers for Medicare and Medicaid Services (CMS), *Health Insurance Marketplace Open Enrollment Snapshot – Week 13* (Feb. 4, 2016) (online at <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-02-04.html>).

obtained health insurance since 2010.³ Further, the uninsured rate for non-elderly adults has declined by 43 percent since the implementation of the exchanges.⁴ To date, the country's overall uninsured rate for healthcare coverage has fallen to a historic low of 9 percent.⁵

II. THE INDIVIDUAL HEALTH INSURANCE MARKET

Since creation of the ACA marketplaces, enrollment in the individual insurance marketplace has significantly increased. One study showed a 46 percent increase in the size of the individual insurance market in the first year the marketplaces were open.⁶ Furthermore, a recent analysis projects that the marketplaces will continue to be sustainable, with modest growth in enrollment expected in the years ahead.⁷

A significant contributor to projections of modest growth in ACA marketplaces is based around the employer-based market. After passage of the law, there were predictions that employers and employees would drop their employer-based coverage at high rates. After initial experiences and calculations, however, the Congressional Budget Office revised its projections, finding little evidence of workers dropping their employer-sponsored health insurance for coverage on the ACA marketplaces.⁸ As a result, fewer individuals are expected to join the marketplaces, as more will remain on employer-sponsored insurance.

The establishment of the exchanges and a new population of insured individuals filled a long-standing coverage gap that existed prior to the ACA. Prior to the law, one study found that 36.3 percent of non-elderly Americans were uninsured for at least one month during the year.⁹

³ HHS, *Health Insurance Coverage and the Affordable Care Act, 2010-2016* (Mar. 3, 2016) (online at <https://aspe.hhs.gov/sites/default/files/pdf/187551/ACA2010-2016.pdf>).

⁴ *Id.*

⁵ Centers for Disease Control and Prevention (CDC), *Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January –September 2015* (Feb. 2016) (online at <http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201602.pdf>).

⁶ Larry Levitt, Cynthia Cox, and Gary Claxton, *Data Note: How Has the Individual Insurance Market Grown Under the Affordable Care Act?*, Kaiser Family Foundation (May 12, 2015) (online at <http://kff.org/health-reform/issue-brief/data-note-how-has-the-individual-insurance-market-grown-under-the-affordable-care-act/>).

⁷ Larry Levitt, et al, *Assessing ACA Marketplace Enrollment*, Kaiser Family Foundation (Mar. 4, 2016) (online at <http://kff.org/private-insurance/issue-brief/assessing-aca-marketplace-enrollment/>).

⁸ Congressional Budget Office (CBO), *How CBO Estimates the Effects of the Affordable Care Act on the Labor Market* (Dec. 2015) (online at http://www.cbo.gov/sites/default/files/114th-congress-2015-2016/workingpaper/51065-ACA_Labor_Market_Effects_WP.pdf).

⁹ Pamela Farley Short, et al, *New Estimates of Gaps and Transitions in Health Insurance*, Medical Care Research and Review (Nov. 5, 2012).

The practice of individuals switching between uninsured and insured, or moving between public and private insurance is common and has traditionally been referred to as “churn.” Churn is a normal, expected component of any multi-payer health insurance system. Typically, churn is more common in lower income populations who experience more frequent fluctuations in income or employment. Churn in the individual market predates the ACA and will likely continue and at higher levels respectively in lower income populations.

For low-income individuals with incomes nearing the upper level of Medicaid eligibility, increased accessibility to individual market insurance on the exchanges is an important entry point to coverage. One purpose of the marketplaces was to provide access to continuous coverage for those who previously faced intermittent periods of uninsurance. A particular study estimated that each year, 50 percent of individuals with incomes below 200 percent of the federal poverty level will experience an income shift sufficient enough to switch their eligibility between Medicaid and the Marketplace.¹⁰ Given this evidence and income-related trends, subsidy availability and marketplace stability will continue to fill a key role in fostering continuous healthcare coverage.

III. ESTABLISHING STABILITY ON THE EXCHANGES

When the ACA marketplaces were established, it was widely understood that the new pool of previously uninsured Americans would present actuarial uncertainty. Actuaries would not have sufficient data on this population to determine the health of the risk pools and, therefore, accurately determine premiums. To ameliorate this uncertainty, the ACA incorporated several mechanisms of risk mitigation during the launch of the exchanges. Referred to as the “Three Rs,” the combination of risk adjustment, reinsurance, and risk corridors were enacted to increase market stability.¹¹ The combination of these three factors was also considered essential to attract insurers to the marketplace since without historical data to ensure ideal pricing, insurers would be assuming a certain degree of risk when determining premiums and rates.

Each of the “Rs” addresses different dynamics expected to emerge in the new marketplaces. Risk adjustment is a system that protects companies with sicker than average patients by transferring a portion of funds from companies with healthy patients to those with sicker. Reinsurance collects fees from all health insurance companies and reimburses companies in a cost-neutral manner to those that experience unexpectedly high costs from patients with catastrophic illness. Risk corridors were designed to redistribute a portion of profits from insurers with unexpectedly high profits to those with unexpectedly high losses. The risk adjustment provision is to remain and be permanent, whereas reinsurance and risk corridors will

¹⁰ Benjamin D. Sommers and Sara Rosenbaum, *Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges*, *Health Affairs*, 30(6):228-36.

¹¹ David Blumenthal, *The Three R's of Health Insurance* (Mar. 5, 2014) (online at <http://www.commonwealthfund.org/publications/blog/2014/mar/the-three-rs-of-health-insurance>).

only last through 2016. Risk adjustment will be permanent to protect against insurers who may find it financially advantageous to seek out healthy patients at the exclusion of the sick.

Of note, the risk corridors program was not executed as originally designed by the ACA. As designed, payments would depend on how closely the premiums insurers charge covered their consumers' medical costs. Insurers whose premiums exceed claims and other costs by more than a certain amount would pay into the program and those whose claims and other costs exceed premiums by a certain amount would receive payments for their shortfall.¹² A provision in the Consolidating and Further Continuing Appropriations Act of 2015 (also known as the "Cromnibus") made it so the insurer payments into the risk corridor program are the only source of funding to reimburse claims, effectively making the program budget neutral.¹³

Subsequently, on October 1, 2015, the Centers for Medicare and Medicaid Services (CMS), which oversees the new marketplaces, announced that claims in the risk corridors program far outweighed contributions to the program for 2014. Insurers submitted approximately \$2.87 billion in risk corridor claims based on their 2014 results, while insurers only owed \$362 million in risk corridor contributions.¹⁴ Therefore, those seeking reimbursement for claims would only receive 12.6 percent of the money (or an estimated 13 cents on every dollar) that they requested from the program.¹⁵ This caused substantial instability, as insurers had to account losses that were not expected.

IV. RATE FILINGS AND RATE REVIEW

The ACA established the Rate Review Grant Program and the Effective Rate Review Program in order to bring greater consumer transparency to the pricing of health insurance products and provide regulators with additional tools to ensure fair, appropriate pricing for consumers.¹⁶ The Rate Review Grant Program provided \$250 million over five years to help states build the capacity to review and document rate increases in their state. Currently, forty-six states and the District of Columbia have an Effective Rate Review Program. The program created minimum standards for the review of proposed rate increases. If a state does not meet the standards, the Department of Health and Human Services (HHS) has authority to conduct the rate review while the state prepares to meet the standards.

¹² CMS, *The Three R's: An Overview* (Oct. 1, 2015) (online at <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-10-1.html>).

¹³ Consolidating and Further Continuing Appropriations Act, Pub. L. 113-235.

¹⁴ *Risk Corridor Claims By Insurers Far Exceed Contributions*, Health Affairs Blog (Oct. 1, 2015) (online at <http://healthaffairs.org/blog/2015/10/01/implementing-health-reform-risk-corridor-claims-by-insurers-far-exceed-contributions/>).

¹⁵ *Obamacare Marketplaces Shutting Down Amid Cash Crunch*, Bloomberg (Oct. 29, 2015) (online at www.msn.com/en-us/money/personalfinance/your-health-plan-will-now-selfdestruct/ar-BBmz1WH?ocid=se).

¹⁶ Public Health Service Act, Sec. 2794.

Rate review requires all issuers that request rate increases of 10 percent or greater for non-grandfathered products in individual and small group markets to submit a rate filing justification to the Secretary of HHS.¹⁷ These requests are placed on state websites, allowing for public notice and comment regarding proposed increases. All rate increases, including those at less than 10 percent, are posted online by August 1st each year. During this time, state insurance regulators evaluate whether increases are reasonable and actuarially justified. In some states, if a rate is deemed unreasonable, insurance regulators have the authority to deny or decrease the rates. A final list of rate increases and premium justifications must be posted publicly no later than November 1st each year, which is the first day of open enrollment in the exchanges.

V. GRANDFATHERED AND GRANDMOTHERED PLANS

Given the size and scope of ACA reforms, certain regulatory exceptions were made to minimize marketplace disruption in the years immediately following passage of the law. First, plans that were already in existence before March 23, 2010, were allowed to continue as grandfathered plans.¹⁸ These plans were required to adopt certain protections, such as ending lifetime limits on coverage, but those requirements did not include other consumer protections such as free preventive care. In addition, so called “grandmothered” plans were sold between the passage of the ACA and implementation of the exchanges. Due to the timing, they did not cover all the required benefits included in the law. Given the less comprehensive and less expensive nature of both varieties of these products, many analysts believe they drew a healthier patient population away from the ACA marketplaces.¹⁹

CMS announced in 2013 that it would permit states to allow grandmothered plans to continue without cancellation for the next year. Subsequently, CMS extended this policy for an additional two years until October 1, 2016.²⁰ Notably, these announcements did not align with insurance companies’ rate-setting timelines. Thus, insurers had already set rates when the transitional allowances were announced. This added to the likelihood of increased year-to-year premium variations. However, when the transitional allowance ends, healthier individuals on grandmothered plans are expected to move to ACA marketplace plans, bringing additional stability to the marketplaces.

¹⁷ HHS, *Rate Review and Annual Report, December 2015*, (Dec. 2015) (online at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Rate-Review-Annual-Report_508.pdf).

¹⁸ Healthcare.gov, *Grandfathered Health Insurance Plans* (online at <https://www.healthcare.gov/health-care-law-protections/grandfathered-plans/>).

¹⁹ Aaron S. Wright, Hans K. Leida, and Lindsay Kotecki, *Ten Potential Drivers of ACA Premium Rates in 2017*, Milliman Healthcare Reform (Dec. 2, 2015) (online at http://www.milliman.com/uploadedFiles/insight/2015/2140HDP_20160107.pdf).

²⁰ HHS, *Extended transition to Affordable Care Act-Compliant Policies* (Feb. 29, 2016) (online at <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/final-transition-bulletin-2-29-16.pdf>).

VI. PREMIUMS IN THE INDIVIDUAL MARKET

Before passage of the ACA, premiums in the individual health insurance market rose significantly on an annual basis. Specifically, 2008 saw a 9.9 percent increase and 2009 experienced a 10.8 percent increase.²¹ Additionally, there was variability between states, with several exceeding premium increases of 10 percent in most years.²² Beyond this, there was little transparency and few consumer protections. Insurers could charge far more or deny coverage for pre-existing conditions. For example, insurers could set annual and lifetime limits on how much health care their beneficiaries could access or rescind coverage once a beneficiary gets sick. Meanwhile, without rate review, there was little scrutiny or recourse. Additionally, the medical-loss ratio was not yet in existence to ensure that premiums were tied to actual health care benefit spending. The medical loss ratio established under the ACA requires insurance companies to spend at least 80 to 85 percent of premium dollars on medical care and quality improvement, not advertising or CEO salaries.²³

Increased consumer choice in the marketplaces and access to advanced premium tax credits have helped address rising premiums and brought greater stability to the marketplace. Advanced premium tax credits are determined based on income, and in 2016, about 85 percent consumers who chose plans on the federal marketplace were eligible for tax credits to help offset the cost of monthly premiums. Moreover, for those consumers with premium tax credits in 2016, premium increases averaged only a net 4 percent, or \$4 per month.²⁴

Given the multiple interacting factors, accurately predicting premiums has proven difficult for experts in the first three years of open enrollment. For example, a 2015 study predicted that for the next plan year, premiums would increase on average by 13.2 percent across the lowest-price silver plans.²⁵ However, from the consumer perspective, this increase did not occur. Rather, on the federal exchange, average premiums increased by 8 percent among all consumers.²⁶

²¹ Jon R. Gabel, *Trends in Premiums in the Small Group and Individual Insurance Markets, 2008-2011*, (Nov. 6, 2012) (online at <https://aspe.hhs.gov/report/trends-premiums-small-group-and-individual-insurance-markets-2008-2011>).

²² *Id.*

²³ CMS, *Medical Loss Ratio* (online at <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Medical-Loss-Ratio.html>).

²⁴ HHS, *Health Insurance Marketplace Premiums After Shopping, Switching, and Premium Tax Credits, 2015-2016*, (Apr. 12, 2016) (online at <https://aspe.hhs.gov/sites/default/files/pdf/198636/MarketplaceRate.pdf>).

²⁵ McKinsey Center for U.S. Health System Reform, *2016 Exchange Market Remains in Flux: Pricing Trends* (Nov. 2015) (online at <http://healthcare.mckinsey.com/2016-exchange-market-remains-flux-pricing-trends>).

²⁶ HHS, *Health Insurance Marketplace Premiums After Shopping, Switching, and Premium Tax Credits, 2015-2016*, (Apr. 12, 2016) (online at <https://aspe.hhs.gov/sites/default/files/pdf/198636/MarketplaceRate.pdf>).

Consumer shopping behaviors, rate review, and premium tax credits are all likely to have contributed to the lower observed premium increases. Evidence shows that consumers who faced price increases were able to shop around to find a less expensive plan. In fact, 43 percent of returning customers to the federal exchange chose a different plan in 2016 than they held in 2015.²⁷ This resulted in the average consumer saving \$42 per month on premiums. Additionally, for 85 percent of consumers, premium tax credits diminished any observed price increases.

VII. CONCLUSION

Overall, the federal and state health insurance exchanges have created a successful and sustainable environment for consumers to purchase affordable, quality health insurance. Some insurers have indicated they plan to stop offering plans on the marketplaces. However, many insurers have decided to expand their ACA offerings into new geographical areas, finding the marketplaces to be a good business investment. Evidence shows that when individuals utilize the marketplaces, they frequently shop around, compare plans, and examine the effects of premium tax credits on the affordability of their selections.

Given the relatively young age of the ACA marketplaces, further changes are likely to come. However, many signs point to increased stability moving forward. Recently, CMS finalized further rulemaking surrounding the exchanges, creating additional regulatory certainty moving forward.²⁸ Additionally, the first three years of claims experience provides additional actuarial data for insurers to navigate the marketplace. Finally, the phase-out of transitional plans and increasing awareness of the individual mandate are likely to add more customers with fewer existing health conditions to the marketplace.

VIII. WITNESSES

Avik Roy
Senior Fellow
Manhattan Institute

Scott Gottlieb, M.D.
Resident Fellow
American Enterprise Institute

Sabrina Corlette, J.D.
Research Professor and Project Director
Center on Health Insurance Reforms
McCourt School of Public Policy, Georgetown University

²⁷ *Id.*

²⁸ HHS, *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017*, Federal Register (Mar. 8, 2016) (online at <https://www.gpo.gov/fdsys/pkg/FR-2016-03-08/pdf/2016-04439.pdf>).